nent discolouration and increased liquidity of the blood. This altered state of the circulating fluid is itself sufficient to give rise to hemorrhage, which, thus occurring alternately as cause and effect, does not allow the patient to escape from its evil consequences. This form of chlorosis is, however, much less frequent than that which is attended by amenorrhœa; it forms only one-fourth of the cases recurring in adults, and perhaps one-twelfth in those of young girls. In twelve cases collected by M. Trousseau, there was no serious lesion of the uterus. It would appear at first view that the treatment adopted for amenorrhœal chlorosis would not be suitable for the menorrhagic form; thus, iron, which is given with so much success to restore the menstrual secretion, would hardly appear appropriate when that secretion is in excess: but is not the effect of iron on chlorotic patients rather tonic than emmenagogue? We generally find the health partially re-established before the menses return; the complexion regains its natural tint, the depraved appetite, the pain at stomach, the palpitation of the heart cease, and the *bruit de soufflet* in the arteries is lost, so that the patient frequently recovers the appearance of health before the menses reappear. Presently this secretion is re-established, in consequence of the general return of the system to a healthy state. Iron then is only emmenagogue because it is tonic or reconstituent. Re-established health is not owing to the returning menses, but the contrary. On this view we shall have no difficulty in conceiving that preparations of iron will be of the greatest utility in menorrhagic chlorosis, in which it will operate both as tonic and hemostatic. Giving freely, the preparations of iron between two menstrual periods, we shall find the blood rapidly regain its lost constituents of colouring matter and fibrine, and the secretion will be much less abundant but more coloured. If more powerful anti-hemorrhagic means are required, the ergot of rye will be very useful. Uterine hemorrhages are generally more violent in the night than during the day, and they occur with the greatest violence about four or five o'clock A. M. Without pretending to account for this singularity, we shall find it highly useful to give a dose of *recently-powdered* ergot (gr. xv. to ℈j.) in the evening, and again about four in the morning. In many cases, the more simple and agreeable administration of acids will be sufficient; of these, the best is the citric, given in its natural form of lemon-juice. If these means are necessary, the chalybeate must be suspended during the menstruation, and afterwards continued whilst any symptoms of chlorosis remain.—*B.* and *F. Med. Rev.* from *Journ. des Connaissances Med. Chirurg.* Dec. 1838.

SURGERY.

31. *On Resection of the Lower Jaw.* By M. Wœnker.—Resection of the lower jaw is made either in the continuity or contiguity of the bone, and ordinarily the half of the maxilla is removed. From 1810 to 1830, it was performed sixty-one times in its continuity, and, from 1793 to 1831, eighteen times in its contiguity. In the sixty-one operations in its continuity, forty-one have proved successful, eleven have terminated fatally, and in the remaining nine the result is not stated. In the eighteen operations in its contiguity, eleven were cured and five died. The deaths of two of these is attributable to the ligature of the carotid artery, that of a third which occurred on the thirtieth day to epilepsy, and a fourth died on the thirteenth day of pleura-pneumonia.

Since the year 1831, eighteen operations on the lower jaw have been performed, of which it will be seen that two only terminated unsuccessfully.

1. In 1831, Schindler, of Grieffenberg, removed from a woman, ætat. 29, the half of the lower jaw for an osteo-sarcoma, which had commenced in one of the alveolar processes. The carotid artery was not tied. The cure was perfect at the end of six weeks.—*Graefe and Walther's Journal*, 1832.

2. Bierkowsky, of Varsovia, performed the same operation for caries of the jaw. The cure was perfect on the forty-ninth day.—*Ibid.*

3. Brett operated with success on a patient, ætat. 27, labouring under an affection of the alveoli.—*Med. and Phys. Trans. of Calcutta*, 1831, vol. 5.

4. Hetting removed the half of the lower and a portion of the upper jaw in a scrofulous woman, ætat. 23, affected with medullary cancer of the bones, soft palate and a portion of the cheek. Despite the large extent of the wound, the cure was complete at the end of seven weeks.—*Prov. Med. and Phys. Trans.* 1833, vol. 1.

5. Martin, surgeon of the Hotel Dieu of Marseilles, performed a resection of the lower jaw.—*Gaz. Med. de Paris*, 1833, p. 688.

6. Goyrand, surgeon of the Hotel Dieu of Aix, removed a portion of the lower jaw for cancer which had affected primitively the soft parts.—*Ibid.*

7. Gerdy removed, in 1833, a portion of the jaw in a man, ætat. 60, affected with cancer, which had commenced in the lip. The patient died of erysipelas.—*Archives Gén.* Septembre, 1835.

8. Gerdy performed the same operation, in 1834, on another patient, ætat. 60, and greatly debilitated, for a cancerous tumour of the alveolar edge of the volume of a walnut. He died on the ninth day of exhaustion.—*Ibid.*

9. Fricke removed from a man, ætat. 60, the tongue and two-thirds of the lower jaw for cancer affecting these parts. Thirty-seven points of suture were made use of to bring the parts together after the operation. A perfect cure followed.—*Zeitschrift für die gesammte Medicin*, 1833.

10. Regnoli, of Pisa, removed by this operation from a sailor, ætat. 48, a fungous tumour of the periosteum, which equalled in size the head of an infant. Perfect success.

11. In 1833, Chelius operated on a woman, ætat. 32, for an osteo-sarcoma, which, sixteen years previously, had necessitated the removal of a portion of the bone.—*Medicinische Annalen von Heidelburg*, 1836.

12. Frank de Casan removed with success a portion of the jaw from a Tartar, ætat. 14.—*Graefe and Walther's Journal*, 1836.

13. Beck disarticulated the lower jaw of a patient affected with caries and necrosis of this bone and extensive ulcerations of the soft parts.—*Communicated by Beck.*

14. Beck in another case removed with success a part of the jaw and coronoid process.—*Ibid.*

15. Beck in a third instance successfully removed the angle of the jaw.—*Ibid.*

16. Chelius has performed the resection of a half of the jaw from an osteo-sarcoma.

17. Pelikan, of Wilna, has successfully performed the partial resection of the lower jaw.—*Graefe and Walther's Journal*, 1836.

18. Jagielski has removed the right half of the bone in a woman, ætat. 44, affected with an osteo-sarcoma of the volume of the two fists.

19. Lastly, the following case observed in the service of Prof. Schwœrer will make known a ninety-ninth case of partial resection of the lower jaw.

Case.—Winkler, ætat. 27, entered the hospital May 24th, 1836, on account of a large cancerous tumour extending from the canine tooth of the right side of the lower jaw to the coronoid apophysis. His general health was bad, he was greatly emaciated and labouring under constant fever. Despite these unfavourable circumstances, it was judged proper to attempt an operation which alone offered any prospect of relief. The patient being seated, the soft parts were divided from the temporo-maxillary articulation to the angle of the jaw, and then by a second incision running along the inferior edge of the maxilla from this point to the chin; a third incision half an inch within the commissure of the lips was directed perpendicular upon the second. The rectangular flap thus formed was dissected off from the bone, and the inferior flap was likewise separated from the jaw, as well as the lower lip to the symphysis. The bone was then sawn through, and the fragment carefully drawn forwards and outwards, in order to separate it from all the internal soft parts as high as the articulation. Arrived at this point, it was drawn still more upwards and outwards in order to

avoid wounding the temporal and external carotid arteries, and the operation was terminated by dividing the articulation with a blunt pointed bistoury. Several arteries were divided, some of which were greatly enlarged, but, by securing each of the vessels as divided, the previous ligature of the carotid, which some authors think necessary, was avoided. The patient being placed in bed, the wound was covered with compresses soaked in ice water. At the end of six hours, the flaps were united by means of ten or twelve points of the interrupted suture. By the tenth day, the wound had united with the exception of a point at which the ligatures passed out. The cure was perfect by the fifth week, and the patient left the hospital in a satisfactory state. The face was scarcely altered, the cheek presenting a linear cicatrix and being but in a slight degree more flabby than that of the opposite side. Mastication and deglutition were easily performed.

This observation, adds M. Wœnker, as the ninety-eighth previously referred to, shows that partial resection of the lower jaw is not in itself an operation extremely serious, and to which a resort is only allowable when death is imminent. It furnishes also some useful data relative to the operative procedure.

Some surgeons recommend that, in resection of the jaw, the patient should be placed in the horizontal position: we think, on the contrary, that an upright position is preferable, as it leaves the operator more master of his motions, and prevents suffocation, cough or the efforts at vomiting, which is caused by the entrance of blood into the trachea or pharynx.

Sometimes after the section of the muscles of the tongue, this organ is drawn back forcibly, and produces suffocation. In cases of this kind Lallemand was obliged to perform laryngotomy, and Delpech to draw the tongue forwards with a hook. This accident may always be avoided by flexing the head forwards, since, as Chelius remarks, the retraction of the tongue is determined by the tension of the sterno-cleido-mastoid muscle. In the second point of view, it is then also preferable to place the patient in a sitting position.

Gerdy, Syme, and some others, think it best, in order to prevent injury to the soft parts, avoid pain, and shorten the duration of the operation, to divide the bone with the cutting pliers; we, however, think with Dupuytren, that the saw when properly handled is always preferable.—*Archives Gén.* for July, 1839, from the *Med. Annal. von Heidelberg*, for 1838.

[The translator of this paper in the Archives Générales in a note says, "The assertion of the author that but eighteen cases of this operation have been performed since 1831, is much too absolute. Several operations are no doubt unknown to him. We ourselves have seen two partial resections of the jaw successfully made by M. Jobert, which are not indicated in his enumeration." We may add that, in addition to the cases here referred to, several others which are not noticed, and which have been performed since 1831 on the continent of Europe, as well as in Great Britain and this country, might be easily added to it. The resumé of M. Wœnker, however, perhaps includes a sufficient number of cases of resection of the lower jaw to allow of a practical appreciation of the immediate dangers of the operation, and, in that view, will prove interesting to the surgeon.]

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32. *On the Treatment of Fractures by the Immovable Apparatus.*—Our readers are already aware that in some parts of Europe, more particularly in France and Belgium, the treatment of fractures by the immovable apparatus has, of late, been revived and extensively introduced into practice. The simplicity of the apparatus, the saving of labour to the surgeon, and its unqualified approbation and adoption by so justly high an authority as that of M. Velpeau, added perhaps to the charm of novelty, have all led to its extensive trial.

The manifold objections to, and dangers of the apparatus were overlooked, and we are but now, after a considerable lapse of time, beginning to hear of the ill success following this mode of treatment. If fractures can be any where well treated by the immovable apparatus, assuredly we should look for them in the hospitals of Paris, where the patients are daily visited by the surgeons who

apply it, and yet we have high authority (M. Malgaigne) for stating, that "the cases of want of success are not rare, and that there is not a single service in Paris in which they cannot be seen."*

The following instances, treated by the immovable apparatus, which we have condensed from the late French journals, are well calculated to show the defects and dangers of this mode of practice when applied to recent fractures. It is true that no method of treatment is at all times successful, much depending upon the care and the skill with which the apparatus employed may be applied, as well as upon the subsequent attention given to the case, but nevertheless we regard that by the immovable apparatus as much more likely to occasion unpleasant results than any other of the methods ordinarily employed in the treatment of this class of injuries.

Case 1. A lady, ætat. 50, of good constitution, received a fracture of the lower extremity of the radius by a fall upon the palm of the hand on the 12th of February. An immovable starched apparatus, with two splints extending beyond the ends of the fingers, was applied, each finger being enveloped with a small roller. Acute pain and fever followed, and on the 8th day delirium. On the 14th of March Dr. Thierry was called to see her; and, perceiving a gangrenous odour from the hand, had MM. Ribes and Berard called in consultation, in whose presence the apparatus was removed. The whole hand was found swollen, and the four fingers were completely gangrenous. The fingers were amputated at the metacarpal articulations, and the flaps brought together with adhesive plaster. On the 24th of March, eighteen days after the operation, the stump was completely healed. The usual apparatus for fractures of the fore-arm was now applied for fifteen days moderately tight, with the view of staightening in some degree the inferior extremity of the radius which projected considerably inwards.—*L'Expérience for* 1838.

Case 2. M. G., ætat. 40, received a compound comminuted fracture of both bones of the leg at their middle part, on the 4th of January, by the wheel of a wagon passing over the limb. He was immediately carried to a maison de santé, where the fracture was reduced, and the ordinary apparatus for fractures of the leg applied. Abscesses followed about the seat of injury and were opened. By the 20th of March the wounds were in a good state, and cicatrising, a small portion of bone having exfoliated, and the union was beginning to be solid. At this time the immovable starched bandage was applied, an opening being left in the apparatus opposite the suppurating point, after which the patient was carefully conveyed once or twice to the garden.

On the 31st of March he left the maison de santé, and, after causing the apparatus to be removed, attempted to walk with crutches; the callus not being sufficiently firm to sustain him, he fell and again fractured the part, the tibia projecting through the wound. M. Thierry was immediately called, and found the leg in a deplorable state. Independently of the protrusion of the bone, large collections of matter existed at the upper part of the leg as well as upon its outer side. The fracture was reduced and dressed with the ordinary apparatus, and the abscesses opened. After a long treatment the patient was cured.—*Ibid.*

Case 3. C———, ætat. 13, had his leg fractured by the wheel of a carriage passing over it. A bandage of strips and three padded splints were made use of. At the end of nine days, the swelling having been dissipated and the leg being straight, an immovable starched apparatus was applied. This remained in place forty days; and, when removed, the bones were found to be united, though with a displacement of the superior fragment of the tibia in front.—*Ibid.*

Case 4. Blanchetien, ætat. 34, entered La Charité, on the 1st of August, for a fracture of the fore-arm in its middle part, produced by a fall from a height of six or eight feet. Up to the sixth day the treatment consisted in bathing the part and the application of cataplasms. At this time the dextrine apparatus was applied.

About the tenth day M. Gerdy, finding the apparatus too loose, filled the inter-

* Gazette des Hôpitaux, No. 110, 1839.

stices with cotton. The ill success of another case in the wards at the same time, in which a similar apparatus had been employed, induced M. Malgaigne on the 1st of September to examine the arm, when it was found that consolidation had taken place, the ulna projecting backwards. The radius also was thrown backwards, and the limb so deformed that the movements of pronation and supination were performed but imperfectly.—*Gazette des Hôpitaux, No.* 110, 1839.

Case 5. At No. 6 Salle St. Jean, (La Charité,) is a man of good constitution, who six months since received a simple fracture of the tibia by a fall. The day after the accident an immovable apparatus was applied, which was allowed to remain on for seven weeks. During all this time the patient appeared to be doing well. When the apparatus was removed, acute pain was felt at the point of fracture; he was unable to walk without crutches; and, after two trials, a displacement of the fragments occurred, consolidation not being perfect. A second application of the apparatus was then made, which it became necessary soon to remove in consequence of the violent pain produced. At his entrance into La Charité, on the 26th of October, a dextrine bandage was applied and allowed to remain for nearly two months. When removed the leg appeared greatly reduced in size, and a considerable deformity existed in the front of the limb. No trace of the provisional callus could be felt, though no motion could be perceived at the seat of fracture.

According to M. Malgaigne, the want of success in the treatment of the above case was owing to the strong compression made by the immovable apparatus. This, being immediately applied, hindered the effusion of the coagulable lymph which goes to form the provisional callus, and the consolidation only had place at a late period, when the definitive callus was thrown out. One of the great objections, adds M. Malgaigne, to the immovable apparatus, is the obstacle which it offers to the formation of the provisional callus, and it is this obstacle which explains *the want of consolidation observed so frequently in this mode of treatment.*—*Gazette des Hôpitaux, No.* 7, 1839.

Case 6. A vine-dresser, ætat. 40, of a good constitution, fell and received a simple transverse fracture of the patella, on the 15th of January. The medical officer called upon to attend him applied first a bandage for the purpose of drawing together the fragments, and afterwards a starched bandage, extending from the toes to the upper part of the thigh; the limb was then put upon an inclined plane. The patient was visited a few times, but, as he scarcely suffered, the apparatus was in no way disturbed. On the 1st of March the attendant returned to remove the bandage, when the odour arising from the limb led him to believe that gangrene had taken place, and Dr. Defer was sent for. Dr. Defer found the limb in the following state: The toes which were not covered by the bandage were completely insensible and mummified. The bandage being removed the gangrene was perceived to extend to within seven inches of the knee and was arrested in its progress. The foot was cold and totally insensible; the epidermis was raised up and was beginning to be separated from the skin. The articulation of the ankle was exposed and the ligaments destroyed. The bones of the leg were also exposed in their lower third, and the tendons were in a sloughy state. Amputation was performed and the patient recovered.—*Gazette Médicale, No.* 28.

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33. *Comminuted Fracture of the Frontal Bone followed by Abscess of the Anterior Lobe of the Brain. Cure.*—Peter Michelet, ætat. 32, received a blow upon the forehead from a heavy stone thrown at him on the 1st of November, 1835. The severity of the blow was such as to knock him down and stun him. After a short time he recovered his senses, and was conducted to his home on foot. The wound bled freely. On the following morning he rose as usual and went on foot a distance of three leagues to market. During his journey he was seized with giddiness and headache which obliged him to stop. Notwithstanding this he continued to rise on the following days and go out as usual, though he had lost his appetite and suffered from heaviness of the head, vertigo, drowsiness and constipation. Despite these symptoms, Michelet remained till the fourteenth

day after the accident without consulting a physician. At this date Dr. De Rivière was called and found the wound almost cicatrised, situated at two inches above the root of the nose on the right of the median line. The scalp in the neighbourhood of the fracture was not adherent to the bone, and on making an incision over the part and introducing a finger an irregular depression of bone was perceived—a blunt probe could be passed into the cavity of the cranium to the depth of two inches. The patient at this time was labouring under slight stupor, drowsiness and constipation, and had involuntary emission of urine, and a strong, slow pulse. Sensibility was perfect. The wound was dressed with a poultice, and a purge and laxative drinks were administered.

On the 16th and 17th the wound was suppurating; the signs of compression of the brain were more marked. Pulse harder and very slow. Venesection; purge repeated; same dressing. From the 17th to the 21st he continued gradually growing worse. At the last date a crucial incision was made over the seat of injury in order to apply a trephine with a view of evacuating the abscess which it was believed had formed in the substance of the brain. Upon exposing the bone, it was found that the depressed fragments could be removed without the aid of the instrument, which was done. Immediately upon its removal a large jet of thick pus, of a greenish colour and very fetid, was thrown out; about two wineglassfuls of this were discharged, the latter part of it being mixed with a dark-coloured matter, apparently the remains of the cerebral substance which had been destroyed. After the evacuation of the pus all the symptoms of compression began to diminish; the patient spoke and aided the assistants to change his linen. The wound was covered with cerate, and lightly supported by means of charpie and a bandage. Absolute diet. The reaction following the operation was moderate, the discharge gradually diminished, and two months after the operation cicatrization of the wound was complete. At the date of publication of the observation (1839) the patient was following his usual occupations, and was in the enjoyment of perfect bodily health, with his mind in no degree impaired.—*Journ. des Connaissances Med. Chirurg. April*, 1839.

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34. *Influence of Position in effecting Reduction of Hernia.*—M. Benoit, in an article in the *Bulletin Medical du Midi*, quotes two cases illustrative of the utility of a recumbent position, with the feet elevated and the head depressed, in effecting a reduction of strangulated hernia. The first of these occurred in the practice of a provincial surgeon. The patient had been suffering from strangulated hernia, which resisted various means employed for its reduction, and it was resolved to divide the stricture. Whilst the surgeon was arranging in an adjoining room the instruments for the operation, a cry of joy from the patient soon brought the surgeon to his side. It appeared that in hopes of alleviating his sufferings, the patient, as he lay on his bed, had elevated and supported his feet against the wall, thus forming an inclined plane of his body, of which his feet were the highest and his head the lowest points. He had not been in this position many minutes when he perceived a rumbling in his abdomen, and the hernia was suddenly reduced.

The second case was one of strangulated inguinal hernia of the left side. M. B. tried the taxis, refrigerants, enemata, &c. without success. The symptoms being urgent, another surgeon was sent for. Whilst awaiting his arrival, M. B. recollected the case just quoted, and placed the patient across his bed, raised his feet against the wall with his head depressed, and in a short time the reduction took place.

Our able correspondent, Dr. S. Jackson, formerly of Northumberland, twelve or thirteen years ago, resorted to the same position as a means of reducing strangulated hernia in one case, and with equally happy results. (See p. 302 of this number.)

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35. *Extirpation of the greater portion of the left Clavicle.*—This operation has been performed by Professor G. Regnoli, of Pisa. The middle and sternal extremity of the clavicle were carious, and were removed, leaving only the

accromial extremity. The patient, ætat. 34, entirely recovered.—*Gaz. Méd. de Paris*, Sept. 14, 1839, from *Annali Medico-Chirurgici*, June, 1839.

36. *Lithotripsy in Italy.*—Several Italian surgeons have devoted themselves with success to Lithotripsy. Dr. Pagello, of Venice, has performed this operation with success on a child six years of age; a Turin professor has performed it on two children between three and four years of age; and Dr. Capeletti, of Trieste, on one of three years and nine months of age. The calculus in this last case was eleven lines in diameter.—*Rév. Méd.* Jan. 1839, from *Annali Univ. di-Med.* 1839.

37. *Statistical Account of the Cases of Stone Operated on in* 1838, by Dr. Rienzi. The number operated on was 36, 33 males and 2 females.

Of these, 19 were between 3 and 15 years, 14 between 16 and 50, and 3 were aged. The lateral operation was not had recourse to in all these cases; with a child the method of Celsus was employed; in the case of a female the calculus was extracted by enlarging with a bistoury a fistulous opening which communicated with the vagina.

Of the 36 operated on, 8 died. Autopsies were made in 5 of these cases. In 2 of them, ulcerations in the bladder existed with effusion of pus and urine into the pelvis. With a third, the left kidney was in a state of suppuration. A fourth had numerous abscesses in the lymphatic glands of the lumbar region of the pelvis. The left ureter was of the size of the small intestine and its parietes thickened and indurated. The fifth was labouring under a second attack of stone, having been previously operated on in 1819. Upon opening the bladder, a large quantity of pus mixed with calculous matter escaped. Death followed in thirty-six hours. The descending branch of the pubis of the right side was carious, and there was a collection of pus behind the symphysis. A scirrhous tumour, of the size of an egg, encrusted with phosphate of lime, existed in the *basfond* of the bladder. On the right side of the neck of the bladder, another tumour existed of the same nature, but in a state of ulceration.

Of the 8 who died, there were 6 adults, 1 child, and 1 advanced in life.

To the number above given, 5 others are to be added operated on by the lateral incision, of which 1 died, and 2 patients operated on at the hospital of Loretto, both of whom were cured.

General Resumé from 1821 *to* 1838.

	Males.	Females.	Cured.	Died.	Children.	Adults.	Old persons.
From 1821 to 1837,	538	15	471	82	282	215	56
In 1838, - -	41	2	34	9	24	16	3
Totals,	579	17	505	91	306	231	59
	596						

Gazette Médicale, No. 37, 1839, from *Il Filiatre Sebesio.*

38. *Statistics of Operations of Lithotomy, performed by Dr.* Campanella.

	Age.	Result.		
1.	6 years.	Discharged	cured on the	14th day.
2.	3 "	do.	do.	13th do.
3.	6 "	do.	do.	16th do.
4.	3 "	do.	do.	15th do.
5.	5 "	do.	do.	40th do.
6.	12 "			
7.	3 "	do.	do.	15th do.
8.	6 "	do.	do.	30th do.
9.	6 "	do.	do.	15th do.
10.	6 "	do.	do.	10th do.

Dr. C. performed the lateral operation by the method of Cheselden.—*Gaz. Méd. de Paris*, 14th Sept., 1839, from *Repert. delle Sc. Fisico-Mediche del Piemonte.*

39. *Statistics of Operations of Lithotrity.* By Dr. Campanella.

	Age.	Result.
1.	18 years.	Discharged cured the 15th day.
2.	30 "	do. do. 40th do.
3.		Died six months after the operation without exhibiting the least alteration in the urinary passages.
4.	44 "	Cured in three operations.
5.	77 "	do. do. do.
6.	57 "	do. 20 do.
7.	64 "	do. 12 do.
8.	75 "	Many operations; two relapses. Cured.
9.	76 "	Cured in one operation.
10.	49 "	do in three do. Discharged in twenty-eight days.
11.	43 "	Discharged in three months entirely cured.

Dr. C. operated at first with the three branched forceps. In cases 5 and 6, he operated by percussion, with Charriere's instrument. In the other cases crushing with this last instrument sufficed. In case 8 there was a stricture of the urethra of forty years duration, which had caused three urinary abscesses in perineum. The bladder was columnar. The first stone seized was two inches long.—*Ibid.*

40. *Moxas of Wafers.*—Professor Graefe employs moxas made of wafers, dipped in a mixture of three parts oil of turpentine, and one part sulphuric ether. It is necessary, before applying this inflammable matter to the skin, to carefully remove the superfluous liquid. These moxas are said to easily ignite, to burn promptly and uniformly, and not to crepitate.—*Lancette Française*, Jan. 29, 1839.

41. *On the Treatment of Inguinal Hernia by Trusses.* By M. Malgaigne. The presence of a direct or oblique inguinal hernia shows a manifest predisposition to the development of a second; so that after an uncertain time, every one who has one hernia should reckon upon having another.

Every bandage hitherto devised for maintaining in place either a congenital or accidental oblique inguinal hernia is formed on a vicious principle, and requires a complete alteration. They all compress chiefly the external ring and act scarcely at all upon any part of the canal; the new principle which I wish to establish and which I have already applied, both in public and private practice, in a number of cases, consists in making pressure on the whole canal; but chiefly on the internal ring. The chief inconveniences of the old method are, 1, that, in closing simply the external ring, it allows the hernia to remain in the canal, and thus does no more than transform a complete into an interstitial hernia; 2, it only by chance produces a radical cure, and, even in children, the proportion of unsuccessful cases is enormous; 3, the hernia is evidently much less effectually detained, as is instantly confessed by the majority of those patients who have tried both methods; 4, when the hernia requires very forcible compression, all the bandages at present employed, by pressing on the pubes, compress the spermatic cord, and hence arises a frightful number of engorgements of the cord and of the testicle, an effect which is not produced by the new method. This method was applied and described by Sir A. Cooper, but is not known or is neglected in England, and is not mentioned in the writings of Samuel Cooper or Lawrence. This singular fact may possibly be somewhat explicable by the following consideration. Ruptures present themselves in practice under two general forms; either simple or reducible with facility, or complicated with serious accidents relating to their strangulation. The latter case, which is

somewhat rare, requires prompt decision, and a dexterous and practised hand; it belongs to the domain of surgery, properly so called, and all the great and magnificent works of the modern schools have been chiefly engaged in the consideration of strangulated hernia. Surgeons have disdained the simple and reducible hernia; they have only superficially studied them, and they have abandoned their treatment to the hands of rupture-bandagers. So that these lesions, so numerous and so important, present in our days the strange anomaly, that surgeons study the disease, but do not occupy themselves about its treatment, and that bandagers are charged with the treatment of the disease without being acquainted with it. I was first struck with this state of things, when first appointed to the care of cases of hernia at the "bureau central" of the Parisian hospitals. The average number of those annually applying for trusses and pessaries is 3000; and in the two months of October and November 1835, I was able to collect 435 written observations, and to obtain results worthy of communication to two academies. Since that time I have silently continued my work, wishing to arrive at results as complete as possible. During the last three years, my employment at the "bureau central" and in the hospitals, my connection with the chief bandagers of Paris, and my private practice, have enabled me to see more than 2000 cases of hernia, to try almost every known bandage, and to determine the conditions under which bandages should be employed, and to place on exact foundations the science of prognosis and of indications. In this place, I merely wish to speak of the treatment of oblique inguinal hernia, the most common of all, and consequently the most important to the practitioner. The oblique inguinal hernia does not always present the same degree of development, and I have assigned to it the following degrees or periods: 1. When the hernia projects only through the abdominal ring; this I call *commencing hernia*. 2. When it occupies the inguinal canal; M. Goyrand has applied to this the name of *interstitial hernia*, a useful name to continue. 3. When it projects beyond the external ring; this is *bubonocele*. 4. When it descends into the scrotum; *oscheocele*. The latter two degrees are well known; the only practical difference which they present relates to the strangulation, which is more dangerous in bubonocele than in oscheocele, but in common cases they offer the same indications, and I shall not stop any further to notice them.

Interstitial hernia is often not recognized, unless it is very large, which is rarely the case; since, upon applying the finger upon the external ring, no projection is felt; the complaints of the patient are ascribed to an imaginary feebleness of the abdominal parietes, or to some other cause. This degree of hernia is very common, and, as strangulation may happen in this case, it is necessary to fix to it serious attention. Lastly, *the commencing hernia*, the first degree of the disease, has been entirely neglected, both by bandagers and surgeons. The reasons of this are easily given. The patient never consults a surgeon at this period of this disease; and I confess that I have not yet had occasion to decide in a case of this kind. It is only in secondary hernia that I have learned to recognize it, after having appreciated all the importance of such a diagnosis; and as this importance results from a fact unknown before my time, it is not to be wondered at, that surgeons, occupied by a large hernia of one side, should be but little careful about an almost imperceptible swelling of the opposite side. But this swelling, however small it may be or may appear to be, is the certain sign of the near approach of a second hernia, and one may vainly check in the most perfect manner the primitive hernia, the second will not the less certainly appear as soon as this slight projection has been perceived. I will return to the subject of these secondary herniæ; I now wish only to establish the course which inguinal hernia generally follows in its development, as far as the fact bears upon treatment.

Hernia most frequently passes successively through these four degrees. Thus, an individual exerts himself and feels a crack in the inguinal region; he sees nothing at first, and it is only after eight or fifteen days that he sees a small tumour projecting beyond the ring, and afterwards the bubonocele becomes oscheocele. From this account, which is applicable to the majority of patients,

one may conclude that the first effort has opened the internal ring, and that the hernia has subsequently passed to the extreme degree. Frequently, in these accidental herniæ, the intestines descend at once into the canal; I have seen some of them suddenly pass to the third degree; and sometimes the hernia becomes strangulated at the moment of its production. But I have never known an accidental hernia suddenly arrive in the scrotum. Each of the first three degrees may remain a longer or shorter period: thus, for example, I have seen the interstitial hernia develope itself so as to acquire half the size of the first, and remain for many years without escaping from the inguinal ring; sometimes, after having made its nidus in the canal, it finishes by making its escape externally; and this long delay in the canal, recognizable by the dilatation of its anterior wall, appears to me to be the essential cause, not hitherto recognized, of the displacement of the vessels of the spermatic cord. This being the state of things, one may judge of the advantage derivable from the application of bandages to the external ring, according to the common method. They transform bubonocele or oscheocele into interstitial hernia, and only prevent strangulation by the external ring, leaving the individual exposed to the danger of strangulation by the abdominal ring. They do not even remedy the common inconveniences of simple hernia; and as the pad does not allow any thing to escape externally, and very much conceals the projection of the canal, the continuance of inconvenience has been attributed to the most fanciful causes. [A case is related showing the inutility of the ordinary bandages. And M. Malgaigne continues,] I might multiply cases of this kind; but any one may make upon the first hernia which he witnesses, an experiment which will lead to the same results. Apply the thumb upon the external ring and nothing escapes externally; the patient says that his hernia is kept up. Place the thumb upon the internal ring, and the patient will say that it is much more effectually kept up, and that he finds, on making any exertion, that there is greater firmness of the abdomen. One may easily understand, also, that as the hernia is not completely maintained by the common mode, a definitive cure cannot be obtained. The external ring only is acted on; the obliteration, if it take place, is only of the external ring, and the canal will always remain open for interstitial hernia. Now and then, as exceptional cases, cures have taken place; but as it has not been possible to reproduce them with any certainty, by the same means, the facts have been doubted. It has been simply believed that the truss sufficed for the cure of young subjects; nevertheless the number of exceptions to this would scarcely be believed. M. Bourat, one of our best bandagers, told me, with an air of triumph, that, out of fifty children, he probably did not fail to cure ten. But this I cannot, from my own experience, believe. I have had innumerable cases of congenital hernia under my own eyes, which have existed twenty, thirty, forty, and in one instance, fifty-three years, notwithstanding the employment of the common bandage. But how comes it that some have been cured, but that others have not? In my opinion, this depends on the form and on the size of the pad. If the pad rest only on the external ring, there will be no more cases of cure in children than in adults. But if by a happy circumstance, the pad be badly made, too large for the object had in view, it rests on the canal, and may effect its obliteration. In young subjects, the canal is so short as to be readily compressed by a pad of moderate size, even badly placed; and the greater vitality explains the more frequent success; but in the adult, very large pads would be required to produce the same effect; and in simple cases, too large a pad is considered as ill made: I have seen a cure of this kind entirely accidental. Lastly, as a pad of moderate size may rest upon the external ring, without being at all supported by the os pubis, it happens, if the pressure is at all considerable, that pain and excoriations of the skin are the consequence, together with engorgements of the cord terminating in varicocele or engorgements of the testicles. Many patients, treated during the late years by the wooden pads of Carpenter, which rest upon the external ring and the pubis, have been compelled to give them up in consequence of pains and excoriations. M. Devergie sent to me a young man with a double inguinal hernia, and at the same time, an orchitis of

each side, the effect of pressure by a common truss. Excepting the complication of hernia with the testicle in the canal, I cannot imagine a more embarrassing case. I have examined at the "bureau central," in a certain number of individuals, what was the proportion of engorgements of the cord and of the testicle. In 200 cases of hernia, I have found sixty-five lesions of this kind; i. e.

Engorgements of the cord, most frequently with varicose dilatation	40
Engorgements of the testicle	23
Atrophy of the testicle	1
Hydrocele	1

One must not, certainly, attribute all these secondary lesions to the action of the truss; for I have found varicocele and engorgements of the cord and of the testicle in individuals who have had old hernia, but who had never worn a truss; and here the cause is the pressure of the hernia itself. And it may be asked, if in the other cases the pressure of the hernia would not have sufficed to produce the same effect; but, in addition to the fact that the action of the truss is too direct to admit of denial, the most favorable conclusion for the common method would be that it is as likely to be the means of producing engorgements of the testicles as herniæ which are not reduced.

The motive which has induced M. Malgaigne to write this paper, is that the old method of employing trusses is almost universal in Paris, and because, as he adds, although the revolution is made in the science, it still requires to be made in practice.

The consequences deducible from what has been said, are, that every hernial bandage which presses upon the external ring, in inguinal hernia, is a bad bandage; and that the first principle applicable to the maintenance of hernia within the abdomen is to make pressure upon the internal ring and upon the canal. The form, dimensions, and degree of pressure of the pad are subjects to be hereafter treated of, together with the questions—In what case is a radical cure by means of a truss, possible? and what are the indications and chances of success?—*B. and F. Med. Rev.*, Oct., 1839, from *Bulletin Gén. de Thérap.*, *February*, 1839.

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42. Roux *on Lacerations of the Perineum and Recto-Vaginal Septum.*—Partial laceration of the perineum is an accident of very frequent occurrence in women who have borne children; but fortunately it is not of serious consequence, as Nature is almost always sufficient to effect a cure.

In some rare cases—where the vulva chances to be directed or turned forwards more than usual, and the perineum is therefore somewhat longer than is common—the rupture has taken place in the centre of the stretched perineum, and the head of the child has actually been protruded through the ruptured opening: M. *Moreau* states that there are at least forty cases of this strange accident on record.

Of a much more serious and distressing nature is the misfortune of a laceration along the whole extent of the perineum, including the sphincter ani and perhaps part of the recto-vaginal septum. As might be expected, this lamentable accident is very generally the result of a first accouchement; and more especially in those cases where recourse has been had to the use of instruments The condition of the patient soon becomes most miserable: the power of retaining the alvine and vaginal discharges is either entirely, or in a very great measure, lost; and as the efforts of unassisted Nature are rarely sufficient to effect a healing of the divided parts, the life of the poor woman is generally wretched in the extreme. True it is, that instances are known where women so affected have contrived to conceal their condition from their husbands, and have actually conceived and given birth to children; but such cases constitute only the exception to the general rule.

As long as the sphincter ani is not torn across, the treatment of a lacerated perineum is quite simple, and is almost always successful. All that is requisite

is, that the patient lie a-bed with the limbs retained close together, and keep the parts clean by frequent ablutions.

The treatment of the more serious accident—when the vulva and rectum are lacerated together, so that they communicate with each other, and form, as it were, a common cloaca—has not certainly been studied by surgeons with that attention which its importance requires.

Even in some of the most recent treatises on surgery, the subject is scarcely, if at all, alluded to. Judging from the reports of such cases as have been published, the attempts to effect a cure have very generally failed. According to M. *Roux*, French surgeons have been seldom willing to interfere, as there seemed to be such feeble hopes of success.

He is now of opinion that the failure has been mainly attributable to the faulty means employed in retaining the disjoined edges together.

It was in 1832 that he was fortunately induced to substitute the use of the *quilled* in the place of the *interrupted* or the *twisted* suture—one of which methods had been hitherto uniformly practised.

Since that period he has operated in eleven cases of complete rupture of the perineum, with the good fortune of effecting a cure in the most of them.

The history of his first case is especially interesting, and deserves to be mentioned. It occurred in a young lady, (the wife of a medical man,) who most urgently requested M. *Roux* to try some operation to relieve her from her miserable condition. The following was performed: The edges of the fissured parts being previously *avivés*, four needles were passed through from one side of the perineum to the other, and the *twisted* suture was then practised, as in the ordinary operation for hare-lip. Every thing seemed, for some time, to promise well; the threads were removed on the seventh day; but two days subsequently the line of union gave way, and the patient was as miserable as ever. She urged, however, a second attempt to be made; and M. *Roux*, having studiously considered all the particulars of the case, now resolved to substitute the *quilled* in place of the *twisted* suture, in the hope of being thus able more effectually to bring the entire depth or thickness of the fissured parts in strict contact, and to keep up a certain degree of pressure on these parts during the process of cicatrization.

Having again made the surfaces to be united raw, he passed a largish dissecting needle, armed with a double ligature, from without inwards, and at about an inch or rather more from the edge of one flap, to the very deepest part of the wound close to the anus; then drawing it outwards, he now passed it from within outwards through the opposite flap. Two other sutures were then passed in nearly the same manner: the one at the centre of the fissured perineum, and the other close to the *fourchette*. The needles having been withdrawn, a portion of a caoutchouc bougie was now laid along the right side of the perineum, between the loops of the ligatures, and the other ends of the ligatures were drawn tightly, so as to cause the bougie to press with tolerable firmness upon the right side of the perineum. A second portion of bougie was now laid along the left side of the perineum between the two threads of each double ligature, and secured in its place by tying the ligatures so close and firm upon the bougie as to cause it to press well upon the subjacent parts: "we need have no fear of drawing the two edges too firmly together," says M. *Roux*. As the lips of a wound are apt to be somewhat everted when a quilled suture is employed, it will be generally found necessary to pass two or three stitches of the interrupted suture, so as to bring and retain them in strict apposition. The following remarks on the superiority of the quilled over every other form of suture, in the accident now under consideration, are extracted from a memoir, which was recently submitted by M. *Roux* to the Royal Academy of Medicine.

Having detailed the particulars of a case wherein it had been successfully used, he proceeds to remark: "We can now judge of the superior efficacy of this (the quilled) suture in the treatment of lacerated perineum. As it is with curved needles that ligatures are passed, it is obvious that a much greater depth or thickness of parts can be embraced than if straight needles were used. The

ligatures, too, although they may have a tendency *se redresser*, in consequence of their two ends being drawn tightly together, can never become so unyielding and so straight, as straight needles—such as are used in practising the twisted suture—must necessarily be. The uniform pressure from the cylinders, placed along each side of the wound, cannot fail at the same time to retain the two edges much more accurately than can be done by means of any other form of suture. We may allude also to the circumstance of the hurtful constriction of the two edges being in a great measure obviated by the interposition of the cylinder between the ligatures and the skin: hence there is much less risk of the sutures working their way out, before cicatrization has taken place. Moreover—and this is not unimportant—all escape of any fluid from the vagina or rectum between the approximated edges, is much more effectually prevented in this than in any other way; as the communication between the bottom of the wound and the surface is quite closed up."

With respect to the medical treatment of the patient, M. *Roux* very properly recommends that she should be kept for several days before the operation on a very light unirritating diet, and that the bowels should be acted upon gently but regularly, so as to remove, if possible, all their fæculent contents. It is of the greatest consequence that they should be quite quiet, and have no tendency to be relaxed on the day of the operation, nor yet for a week afterwards; as it must be obvious that the efforts of the rectum to empty itself must necessarily tend to strain, and perhaps to burst open again, the recently-united surfaces. In some patients it will be found necessary to exhibit opiates, for the purpose of inducing the requisite constipation. During the first six or seven days, the food and drink must be taken in as small quantities as possible. At this time, if hitherto there has been no action, a gentle aperient may be given, before the ligatures are withdrawn—which step should not be taken until the following day.

As affording another precaution to prevent any disturbance of the wound, the urine should be drawn off with the catheter at regular intervals: perhaps the best plan is to leave the instrument in the bladder. It is scarcely necessary to add, that the patient must remain entirely quiet: to prevent the movement of the limbs, they should be tied together.

We shall now briefly mention the result of the eleven operations which M. *Roux* has performed for the cure of lacerated perineum, by means of the *quilled* suture. In all, a copious suppurative discharge from the vagina followed on the second or third day, and an uneasiness, more or less considerable, was experienced in voiding the urine. That portion of the fissure nearest to the anus is almost always the latest of healing. At this point there usually remains for some time after the rest of the wound has cicatrized a small gap, such as follows the operation for fistula ani; and even when the greatest care has been taken to pass one of the ligatures through the *eperon* of the recto-vaginal septum, a length of time is required before the communication between the two passages is entirely obliterated;—the escape of the intestinal gas and fæculent contents retarding the complete coalescence of the edges of the opening. By proper attention, however, and by the occasional application of the nitrate of silver, the fistula gradually contracts, and will ultimately cicatrise. Of the eleven cases, a cure was effected in seven by a single operation. In one the operation was unsuccessful the first time, but succeeded perfectly the second time. Two of the patients died—one from the effects of phlebitis, or of purulent absorption; and the other, (in whom the laceration of the perineum was complicated with prolapsus of the rectum and of the vagina,) from chronic-enteritis, to which she had been long subject. In the remaining case, every thing went on favourably till the fourteenth day, when, after a sudden action of the bowels, the adhesion of the united surfaces gave way: a second operation is, however, to be performed.

Before drawing our remarks to a close, we shall very briefly allude to those cases, where a fistulous communication between the rectum and vagina, unaccompanied, however, with any laceration of the perineum, has taken place.

It is a much less serious accident than that of which we have been treating hitherto. Under judicious management, the efforts of nature alone will generally suffice to effect an obliteration, unless the fistulous opening be very considerable.

M. *Saucerotte* mentions a case, where the perineum and part also of the recto-vaginal septum were lacerated during a difficult parturition, the sphincter ani, however, remaining entire. Four months after the occurrence of the accident, the edges of the fissure were *avivés*, and brought together by means of six points of the interrupted suture. The bowels were not allowed to act for eleven days; but then, after an evacuation, three of the stitches gave way: the extent of the laceration, however, was reduced by one half. A second operation was, therefore, performed; the sphincter ani was first divided, and after paring the edges of the fissure anew, four stitches were introduced. After the lapse of three months the fistula was quite healed.

On this case M. *Sedillot* has, it appears to us, very justly remarked that the sutures seem to have been not only of no use, but rather to have retarded the process of cicatrization; and that if merely the edges of the fissure had been *avivés*, and the sphincter ani divided,* the cure would probably have been much more rapid. This opinion is confirmed by the result of a case reported by *Noel* in 1794. In this case the entire perineum, the sphincter ani, and a portion of the recto-vaginal septum had been lacerated. After the edges of the fissure had been made raw, the perineum was brought and retained together by means of two twisted sutures, one near the anus and the other close to the *fourchette*. The limbs of the patient were then tied together; and an open state of the bowels was encouraged by the administration of laxative medicines.

On the sixth day after the operation, the anterior needle being withdrawn, all the alvine contents were found to pass by the anus; the second needle was not removed till the twenty-fifth day, and by that time *the whole had cicatrised.*

It may, therefore, be fairly questioned whether it is very advisable to employ sutures in the treatment of a recto-vaginal fistula. If the perineum be lacerated at the same time, the attention of the surgeon should be mainly directed to get rid of this accident, and leave the contraction and coalescence of the fistula to nature, after paring its edges, and perhaps occasionally touching them with some stimulant or caustic.—*Med. Chirurg. Rev.*, from *Journal des Connais. Med. Chirurg.*

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43. Jobert *on Internal Piles.*—It is now generally admitted by surgeons, that excision is the most effectual, and at the same time the least dangerous, method of removing internal piles. The only serious objection to its adoption is the risk of consecutive hemorrhage. "In two-fifths of the patients on whom I have operated," says M. *Dupuytren*, "and in whose cases I did not employ any hæmostatic means after the excision, an internal hemorrhage supervened." The quantity of blood thus lost in some cases is very alarming, the rectum and even the greater part of the colon becoming filled. Several patients have died in consequence. The absence of valves in the veins of the portal system will account for the profusion of the discharge.

To prevent this alarming accident, *Dupuytren*, after having tried all other expedients, declared that the only one to which the surgeon could safely trust was the actual cautery applied to the bleeding surface. He assures us that by this means he always avoided any consecutive bleeding.

M. *Jobert*, however, states that he has, on several occasions, known alarming hemorrhages supervene after the use of the cautery. It is also to be remembered that this violent remedy always induces most distressing inflammation and tumefaction of the cellular and adipose tissue of the anus, and that the rectum and bladder not unfrequently sympathise most severely. To avoid these

* Mr. *Copeland* has, we believe, recently pointed out the advantage that may be derived in the treatment of recto-vaginal fistulæ, from dividing the *sphincter ani*. It would seem that in this idea he has been anticipated by the French surgeons.

inconveniences, M. *Jobert* has, of late years, adopted the following practice in preference:

The patient having made the piles to project out as far as possible, the surgeon lays hold of them by means of a hook, so as to retain them there as long as is necessary, and divides them slowly and carefully, applying a ligature to each vessel, as it starts; (je les devise lentement, *et à mesure qu'un vaisseau fournit du sang, j'en opere la ligature au moyen d'un fil simple.*)

The gut should not be returned immediately; but if, after it has been well sponged, no bleeding points be seen, it may be replaced with a perfect assurance that no consecutive hemorrhage of any importance will follow. The patient usually recovers without much suffering.

M. *Jobert* has related several cases in illustration of his practice.

A gentleman had for upwards of ten years suffered exceedingly from pain and suffering after defæcation, in consequence of numerous piles, internal as well as external. Some of these were ulcerated on their surface; and hence an almost constant purulent discharge and occasionally also very copious hemorrhages flowed from the bowel. To add to the patient's sufferings, the gut became frequently prolapsed after every alvine evacuation. M. *Jobert* advised him to submit to an excision of the hemorrhoidal tumours. Several arteries and large veins were tied; no hemorrhage followed; and, at the end of fifteen days, the patient was completely well.

The case also of a lady, who for several years had suffered martyrdom from the anus and extremity of the rectum being almost quite plugged up with a mass of hemorrhoidal tumours, is detailed at considerable length. M. *Jobert* at first hesitated what line of practice to pursue, in consequence of the size of the varicose vessels, and of the extent of the disease. At first he proposed to adopt *Dupuytren's* method of using the actual cautery after excising the tumours; but finally he followed the plan recommended above—*c'est à dire la section graduée et la ligature des vaisseaux à mesure qu'ils etaint devisés.*

The cure was quite satisfactory.

M. *Jobert* assures us that he has now adopted this practice in a great many cases, and he is convinced that it is by far the most advisable for the removal of internal hemorrhoids.—*Ibid.*, from *Gaz. Med. de Paris.*

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44. Jobert *on Fissures of the Anus.*—It is only of late years that this most troublesome and distressing affection has been properly understood. It used to be confounded with syphilitic rhagades and ulcerations. It is to the late Baron *Boyer* that we owe the first right description of the disease, and of the most successful mode of treating it. Regarding the fissures as the result or consequence of a spasmodic contraction of the sphincter ani, he showed the necessity of dividing the margin of the anus including the fibres of this muscle; and his practice has been almost universally followed.

The practice is right; but the theory is more than questionable. The spasmodic contraction of the sphincter seems to be rather the effect than the cause of the ulcerated fissure of its mucous covering and of its surface. It is the irritation, to which its superficial fibres are exposed, that induces the spasmodic contraction of the muscles. It is of importance to attend to this circumstance, viz. whether the ulceration is limited to the mucous lining of the gut or whether it has extended to the fibres of the sphincter ani, in the management of the disease. In the former case it is rarely necessary to have recourse to the scalpel; the ulcerated fissure will generally heal under the use of caustics, &c. But when once the fibres of the sphincter are involved, and the consequent spasmodic contraction of the muscles is induced, the application of any irritating substance tends only to aggravate the suffering, and the only successful mode of treatment, it has been supposed, is fairly to divide the muscles across.

M. *Jobert* has found, however, that even under the latter circumstances, it is not always necessary to effect a complete division of the muscles—one of the occasional troublesome results of which is to cause an incontinence of the rectum.

He has succeeded in removing the disease by simply excising, either with a scalpel or with scissors, the membrane lining the ulcerated surface and a small portion of the subjacent soft parts: the fissure is thus brought to the state of a simple wound, and the pain occasioned by the contact of the two lips no longer continuing, the spasmodic contraction of the sphincter ceases.—*Gazette Médicale.*

In a recent number of the Journal "*Experience*," M. *Mondiere* has published several cases of fissure of the anus successfully treated by the introduction, night and morning, of bougies (*meches*) of lint well smeared with an ointment composed of lard, sugar of lead, and extract of belladonna; and, when the contraction of the anus is overcome, by the application of lunar caustic to the surface of the fissure. It is to be remembered that the introduction of any foreign substance into the rectum, when a fissure exists, is almost always attended with severe pain. We must not, therefore, be induced to discontinue the attempts to dilate the anal orifice, although the patient should complain for some time after each introduction.

M. *Mondiere* does not seem to have been aware of the distinction in cases of fissure of the anus pointed out by M. *Jobert*, and mentioned above.—*Ibid.*

45. *On Torsion of the Arteries.*—Dr. Remak recommends a modification of the operation of torsion of the arteries, which consists in seizing the vessel transversely with a pair of sharp wedge-shaped forceps, and then pressing forcibly, so as to divide the internal coat. The extremity of the artery is then seized with another pair of forceps and twisted, while the torsion is prevented from extending up the artery by the first pair. The vessel is thus less injured than in the common proceeding, and the internal coat, which shrinks after being divided, offers an effectual barrier to the blood. The operation was tested experimentally upon a horse: the carotid was divided, and torsion, performed as recommended above was sufficient to restrain the hemorrhage, even when the horse was made to trot briskly.—*B. & F. Med. Rev.*, from *Med. Zeit.*, *No.* 6, 1839.

46. *Artificial Anus formed in the left Lumbar Region.*—In our preceding No., p. 228, we noticed a case in which this operation had been performed by M. Amussat, and we find from recent journals, that it has been again resorted to by the same distinguished surgeon in a second case.

The subject of the latter was a M. T., aged 62, of a very feeble constitution, and habitually a sufferer from costiveness and piles. "Defecation was accomplished with extreme difficulty, and the fæces frequently accumulated in the rectum so as to render it necessary to extract them. The stools were generally passed with blood.

"For the last three years, in addition, the fæces were mixed with purulent and ichorous mucus, and exhaled a very fetid odour. The different methods of treatment adopted by this serious affection, which seemed to be seated in the great intestine, were of no advantage.

"M. T. consequently determined to come to Paris, about the 15th of May, 1839. His strength diminished every day, and he was extremely thin; and when the stools came away after the constipation, which was continually increasing in obstinacy, he felt excessively exhausted.

"Dr. Foville being consulted examined the rectum, where he ascertained that at the distance of two inches and a half from the sphincter there was a carcinomatous tumour, which had ulcerated, and which in some measure blocked up the intestine. This tumour was formed by a scirrhous prominence in the shape of an irregular ring studded with knots, into which it was difficult to introduce the end of the forefinger. On inserting a *porte-empreinte*, it was found that there was a stricture an inch and three-quarters in length. The obstacle which had stopped the course of the fæces, and the real source of the morbid secretion, were now ascertained. The correctness of M. Foville's diagnosis was acknowledged in a consultation at which MM. Recamier, Amussat, Breschet, and Puyoo, were present. Different modes of treatment were proposed. Both dilatation and the use of a ligature were rejected. Excision was equally objected

to, as it was feared that even a slight hæmorrhage might be fatal to a patient who was already so remarkably weak.

"The method finally resolved upon was to crush the tumour, which was proposed and put into execution by M. Amussat, on the 30th of May. The operation was performed with long forceps which pinched and crushed the most prominent points of the cancerous tumour. The patient felt scarcely any pain. Nothing came away during the operation but a small quantity of blackish blood mixed with ichor. A sort of fleshy detritus was discharged at the same time by the anus. It was thought proper to keep up a continued stream of cold water in the rectum, in order to prevent the occurrence of inflammatory symptoms.

"Some sloughs or fragments of atrophied membrane came away in consequence of the efforts made to detach them.

"A week after this operation it was agreed that to complete its effects, cauterization would be necessary; M. Amussat cauterized seven times, by means of a speculum and cylinders of caustic potash, with intervals of three or four days between each application, without any sign of inflammation appearing about the bladder or peritoneum.

"Each time that the patient was cauterized, small refrigerating clysters were prescribed. Under the influence, either of the crushing or the cauterizations, which were applied from below upwards, and from within outwards, the tumour was reduced to little more than half its size. Meantime, M. T.'s general condition grew worse. The stools did not occur till after a lapse of ten or twelve days, and then with such violence as to lower the patient till he nearly fainted. His attenuation was extreme, and the skin on the sacrum was on the point of ulcerating. Hence, it was not thought prudent to continue the cauterizations, which must have been multiplied, in order to destroy by successive layers what still remained of the tumour.

"M. T.'s symptoms were so extremely serious, that the only alternatives were to abandon him to a speedy death, or to adopt the only resource of the surgical art in such circumstances. The operation for artificial anus, which had lately been crowned with success, naturally suggested the thought of trying it on the present occasion. The double object might here be attained of remedying the retention of the fæces, and obviating their action upon the diseased rectum. On the 13th of July, there was a fresh consultation, at which Dr. Seguin was present, in addition, and at which the necessity for the operation was unanimously resolved upon. It was performed by M. Amussat on the following day according to the method he had already followed.

"An incision four inches and a half in length, at the distance of four fingers' breadth from the spinous processes of the vertebræ, was made in the middle of the space comprised between the last false rib and the superior margin of the os ilium.

"Towards the anterior angle of the wound a membranous projection was observed, formed by the peritoneum, and below which seemed to be the small intestines.

"The colon in the left lumbar region was strongly drawn back upon itself, and was covered in a great measure by the quadratus muscle, whose fibres it was necessary to cut across. The intestine having been taken hold of with the necessary precautions, was incised in about the posterior half of its circumference. Nothing came out but gases and some small balls of fæcal matter. The colon was then drawn towards the anterior commissure of the incision made in the integuments, and fixed there by four stitches of the interrupted suture. Three stitches of the twisted suture were then passed through, to bring together the lips of the wound, but leave the intestinal aperture entirely free.

"There was no general reaction, so to say. The feverishness under which the patient had continually suffered for a long time, particularly towards the evening, was scarcely increased during the three or four days which followed the operation.

"In spite of the opening thus made in the digestive tube the fæces did not immediately change their course; watery injections thrown into the colon passed

entirely by the natural anus. The anormal orifice did not give vent to the fæces till the 18th of July, and the evacuation was very copious. For some days the fæces continued to pursue their accustomed course, gases and liquids alone being discharged by the lumbar aperture. In order to dilate this orifice, it was necessary to employ, in succession, prepared sponge, elastic gum tubes, and at last wax bougies. These dilating substances facilitated the passage of the fæces by the artificial aperture.

"To sum up, M. T. is evidently in better health than he was three months ago. He has been able to set off for his residence in the country. The hectic fever has disappeared; and the skin, which was yellow, and of an earthy tint, is growing clear. All the functions have been re-established as well as so long and so great a deterioration of the system will permit. There is no longer any tympanitis, nor any forced stagnation of the fæces. The stools are regular, and figured fæces are expelled from the artificial orifice.

"The tumour in the rectum has remained stationary; it has merely become harder, which must render it less capable of being irritated by the contact of the fæces, which may still continue to pass by the rectum, but which do so less and less every day.

"Narcotic and chloruretted injections were indicated."

This as well as the previous operation speak in favour of Callisen's method as modified by M. Amussat. These modifications are as follows:—"1. Instead of an incision parallel to the external margin of the quadratus, he makes a horizontal one, which renders it more easy to uncover the intestine, and carry it to the anterior angle of the incision.

"2. The intestine is incised only in the posterior half of its circumference. This precaution will doubtlessly prevent the troublesome protrusion of the mucous membrane externally, and it will facilitate the cure of the artificial anus itself, when the obstacle which has opposed the expulsion of the fæces has disappeared. This kind of obstacle comprehends various causes susceptible of being removed or combated, such as hardened and accumulated fæces, polypi and other tumours, calculi, syphilitic vegetations, collections of different kinds in the pelvis, &c.

"Thus art may hope to remedy the inconvenience which it has caused for the preservation of the patient; but, if we cannot hope to re-establish the natural course of the fæces, their new mode of passage will have a favourable influence on the morbid growths existing in the sigmoid flexure of the colon or in the rectum. The vitality of the tunics of the intestines being diminished, the pathological alterations of a scirrhous character situated in them will go through their final transformations more slowly; and this slackening in their destructive progress will be another benefit derived from the artificial anus.—*Lond. Med. Gaz.* November, 1839.

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47. *Historical Notices on the Occurrence of Inflammatory Affections of the Internal Organs after External Injuries and Surgical Operations.*—This is the title of a very interesting paper in the Number of the *Edinburgh Medical and Surgical Journal* for October last, by Dr. William Thomson. The following are the conclusions which the author draws from his researches:

1. That individuals labouring under a chronic affection of any internal viscus are liable to have an acute inflammatory attack induced in that viscus, by local injuries of remote parts of the body.

2. That inflammatory affections of different organs and textures are liable to occur in individuals who have suffered local injuries, but in whom there is no reason to suppose any disease of these viscera to have existed previously.

3. That different viscera are liable to be affected in different cases of injury of the same part of the body; and that, on the other hand, the same viscera may become affected in cases of local injury of different parts of the body.

4. That in many instances of local injury, pus is effused into remote organs, though suppuration has not occurred in the seat of the primary injury.

5. That the recurrence of affections of remote organs in cases of this nature

is generally accompanied by some change in the appearance of the primary injury—as the cessation of the effusion of pus in cases in which suppuration had commenced.

6. That these secondary affections of remote organs occur at very different intervals of time after the reception of the primary injury.

7. That symptoms occasionally occur in cases of this nature, that enable the practitioner to determine which organ is affected—as cough, when the lungs, and jaundice when the liver, become inflamed.

8. That in most instances, however, the progress of the disease in the remote viscera is very insidious, and affords few or no indications of its existence.

9. That the most probable mode of preventing the occurrence of inflammation in remote organs, subsequently to injury or amputation, is to moderate the constitutional inflammatory tendency, which local injuries produce to a greater or less degree, and particularly to direct these precautions to the organs that may be known to be predisposed to disease, or that show any tendency to become affected.

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48. *Tracheotomy in Croup.*—It appears from a recent discussion at the Royal Academy of Medicine, that of 140 patients labouring under croup, on whom tracheotomy had been performed, 28 were cured, and 112 died. When the character of the disease is considered—the aggravation of the inflammation likely to be occasioned by the incisions into the inflamed part—and the delay and difficulties generally thrown in the way of the operation, this result is more encouraging than we had been led to expect.

The following table shows the names of the operators and the results in the cases alluded to:

M. Amussat, operations	6, cures	0, deaths	6
M. Baudelocque,	15,	0,	15
M. Blandin,	5,	0,	5
M. Brettoneau,	18,	4,	14
M. Gerdy,	6,	4,	2
M. Roux,	4,	0,	4
M. Trousseau,	80,	20,	60
M. Velpeau,	6,	0,	6
	140,	28,	112

Journ. des Connaiss. Méd., June, 1839.

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49. *Cases of Chronic Hydrocephalus successfully treated by Pressure.* By J. F. Barnard, Senior Surgeon to the Walcot Dispensary.—The following cases illustrate the efficacy of a mode of treatment which Mr. Barnard strongly advocates in chronic hydrocephalus. Mr. Barnard informs us, that he was led to adopt this plan of treatment "from observing some adult heads, of such a size as could have been caused by no other than hydrocephalus in infancy." In these cases nature probably had effected a cure by a comparatively early union of the bones of the head, thereby forming a natural and most efficient bandage. Hence, the obvious indication to imitate nature and apply gradual compression to the head.

Case 1.—A child, about a year and a half old, was born to all appearance healthy, and continued so until six months old; when the head was first observed to increase in size. Mr. Barnard did not see it until the disease was so far advanced as to make him almost despair of its terminating favourably. The head was exceedingly large, weighing nearly as much as two-thirds of the rest of the body, and measuring in circumference twenty-two inches and a half. The child lay in a state of stupor, and was unable, in the least degree, to move its head. There was slight strabismus and a rolling of the eyeballs, and almost constant startings of the muscles of the whole body, but more particularly of the face. The countenance had a cadaverous appearance, and the skin was of a yellowish colour; the eyes were sunk in their sockets, and enclosed in a dark ring. The

flesh was flabby and seemingly hanging on the bones; the evacuations from the bowels were particularly unhealthy, sometimes green, sometimes blackish, but never of a healthy colour, nor indeed had they been healthy since half a year after its birth. The tongue was constantly covered with a thick white coat; when its head was moved it screamed, and seemed sensible of pain. The head was directed to be shaved perfectly clean, strips of adhesive plaster, about three quarters of an inch wide, were then applied completely round the head from before backwards, and so that the ends overlapped each other two inches behind, and covering the space from the eyebrows to where the hair commences, and as low down as the ears would permit; then, with cross strips, from one side to the other, over the crown of the head; and, lastly, one long strip, reaching from the forehead within half an inch of the root of the nose over the crown of the head, likewise to the nape of the neck. This gave effectual support to the parietes of the cranium. The whole head was kept constantly covered with linen dipped in cold water, and the child took no other medicine than a little castor oil, when the bowels required it. The good effects of this practice were evident; in less than a week the little patient could move its head much better, the squinting had disappeared, the secretions from the bowels were more healthy, and the startings of the muscles were less frequent, He had not screamed on rolling or moving the head since the bandage was applied. In a fortnight, the size of the head was reduced in circumference three quarters of an inch; the child was more lively, and began to take notice of the persons around it; the secretions from the bowels were perfectly healthy and evacuated regularly; the tongue nearly clean, and the skin of a natural colour; the countenance more composed and animated.

Two months after the bandage was first applied, the child appeared in every respect healthy, but the head was still larger than it ought to be—measuring twenty inches and rather more in circumference; the flesh was firm, and the skin of a healthy mottled hue. The bandage was worn about two months longer, having been renewed about once a fortnight. The bones were then united, and the head firm, and the child well, only requiring time to bring its muscles into action which had been so long quiescent.

Case 2.—J. W., a child, ten months old, who, according to the account received from the parents, was born perfectly healthy, and remained so for a month, when it appeared to fall into a sickly and unhealthy state, as they supposed from dry nursing, the mother being unable to suckle it. Two medical men in succession had been consulted, without advantage, and the head, I was told, had been enlarged for some months. It now measured twenty-one inches in circumference; the fontanelles were quite open and distended, and the bones loose and moveable; the complexion sallow, face bloated, muscles relaxed and flabby; pupils dilated and insensible to light, strabismus, and sometimes convulsions. She lay in a half comatose state, and appeared to be insensible to things passing around her; bowels regular, but excretions unhealthy. Mr. Barnard directed the head to be shaved, and then applied the adhesive plaster in the manner described, omitting the application of cold water.

March 5. In a week the general symptoms were improved, secretions from the bowels healthy, and the squinting gone; head not decreased in size; plasters firm; had taken her food better.

16. Has had no convulsions since second; bowels still continue regular, with only one dose of castor oil; countenance much improved, and complexion clearer; begins to take notice of things passing around her.

April 10. Plasters have begun to loosen; they were, therefore, removed, and fresh applied. The head was found to have decreased half an inch.

From this time the health of the child regularly progressed, and every bad symptom had left her by the end of the month.

May 6. The child has gained flesh, and the muscles become much firmer. Appetite good, and has generally a healthy appearance. The plasters were again renewed, and the circumference found to have decreased an inch. They were again renewed in the beginning of June, and left off the following month,

when the child appeared in perfect health, the head measuring eighten and a half inches.

Case 3. January 15.—Jane Parfitt, a child eight months old, was born with a large head, which has sensibly increased up to the present time. Both the anterior and posterior fontanelles are very open, and the parietes distended; the bones of the skull are thin, moveable, and separated from each other. She is constantly in a recumbent position, from inability to sustain the head upright; pupils dilated, and insensible to light; slight strabismus, occasional convulsions, and great restlessness, sickness, and unnatural secretions from the bowels; appetite good, almost voracious, face pale and emaciated; an inattention to surrounding objects, amounting almost to coma. The head was shaved, and the plaster bandage applied; the circumference of the head is nineteen inches. The compression produced no additional uneasiness, nor any increase of symptoms. Castor oil to be given occasionally, if required.

During the first month there was little apparent alteration in the size of the head, or the state of the patient, excepting that the convulsions were thought to be not so frequent, and the evacuations had a more healthy appearance. The castor oil had only been given twice; strapping quite firm.

March 2. Has had no convulsions for a fortnight; strabismus gone, evacuations natural and regular; head appears to be gradually getting firmer; expression of the face much more pleasant and healthy; sleeps well.

15. The plaster was renewed as it had become corrugated in several places; the long strip, from the forehead to the occiput, was omitted, as from the increased firmness of the head it appeared to be useless. At this renewal the head was found to have decreased in size half an inch.

The case went on well for six weeks, without one untoward symptom. The child has increased in flesh; the evacuations are natural; the convulsions and restlessness have entirely disappeared; the head is much firmer; the fontanelles are smaller, and the sutures are nearly closed.

May 3. Strapping renewed; the head, by measurement, has diminished but little; the child is better able to move it, although the muscles of the neck have not yet sufficient strength to sustain it. Has cut four teeth since the commencement of the treatment.

From this time the little patient gradually improved in health and strength. The plasters were again renewed for the last time about the latter end of July; the child was now able to hold up its head with but little oscillation. In September it appeared in perfect health, with a head rather larger than common (measuring about eighteen inches in circumference,) but quite firm in every part, excepting a small portion of the anterior fontanelle. Mr. Barnard saw the child twelve months after, when it seemed, in every respect, to be well.

Case 4.—At six months old I decided on submitting to the process of compression the head of this child, which measured nineteen and a half inches in circumference. The fontanelles were much opened, and distended with fluid; the bones loose and moveable. The child was perfectly unable to sustain its head, and lay constantly in a recumbent posture; the countenance bloated and indicating distress; pupils dilated and insensible to light; strabismus, restlessness, and occasional convulsions; skin dry and harsh, and urine scanty; bowels rather costive. The head was shaved, and the plasters applied on the first of June.

June 15. There is a marked improvement in the state of the child; he was much quieter, and the strabismus had disappeared; the pupils contracted little on the admission of light; countenance better; plasters firm.

July 2. Have had some trouble in keeping the bowels open with castor oil, but the child in every respect is better, the countenance with rather a comfortable expression; skin soft; and urine passed in a natural quantity. The plasters were renewed, and the head found to be reduced in size full half an inch.

24. The plasters again renewed. The child continues improving; the face has now a natural and pleasant expression, and every symptom of anasarca gone; bowels more regular, and requiring castor oil only about once a week. After

this the plasters were twice renewed, and the patient gradually improved, both in health and strength, until the beginning of October, when he was attacked with measles, which, however, he passed through favourably; and in the beginning of December, appeared to be in perfect health, with the head reduced to eighteen inches, and quite firm, except the anterior fontanelle, which was still partially open.

Case 5.—A child, twelve months old, whose head was observed to have been increasing in size for the previous four months, now measured in circumference nineteen inches; the fontanelles and sutures were much open, but the parietes were not particularly distended, although fluid could be distinctly felt; the whole head was loose and flabby, and the bones as it were floating; the countenance shrunk and pallid, and the body generally much emaciated; pupils dilated, and one eyelid dropped, which the patient seemed perfectly unable to lift; slight convulsions occasionally; but usually it lay in a quiet, sleepy state; took its food rather voraciously; the bowels irregular, sometimes loose and sometimes costive but the excretions always unhealthy. It had been attended by three separate medical gentlemen, who had given up the case as hopeless.

The head was shaved, and the adhesive bandage applied on the 10th of March; and, although compression was carried to a much greater extent than I had ventured on in any other case, no untoward symptom followed.

For three months no particular change in the state of the child took place; at this time, June the 10th, although the plasters were still firm, I thought it well, from the growth of the hair and other circumstances, to renew them, which accordingly I did. The bowels were still irregular, requiring occasionally a dose of castor oil, which answered the purpose exceedingly well, and no other medicine was given; the appetite still continued good; the food consisted of bread and milk and arrow-root.

July 15. The plasters again renewed; no particular change in the state of the patient. The head appeared rather firmer, but no alteration in size; the bowels more regular, and evacuations somewhat improved. Diet ordered to be altered to beef-tea and jellies.

September 5. Both eyelids in perfect action; no convulsions; bowels regular, and evacuations healthy; countenance expressive of ease and comfort; can sit up with little assistance, and appears lively; head much firmer, and reduced in size half an inch; gains flesh.

October 29. The head is firm and the sutures quite closed: the child begins to walk about, as yet rather staggering; plasters left off. The child continued to progress, and in three months was restored to perfect health.

Case. 6.—A child, three months old, was born with rather a large head, which had increased gradually up to this time, and measured seventeen inches. The symptoms were similar to the former cases, with the exception of squinting, and no dropping of the eyelid. The head was shaved, and the plasters applied on the 15th of August. In two months the condition of the child was much improved; the head firmer; no convulsions; bowels regular, and evacuations healthy. The plasters were reapplied twice in the course of the following three months, and no untoward symptom had presented itself. By the end of January, the child appeared perfectly recovered; the sutures had quite closed, and the anterior fontanelle nearly; but, strange to say, the head had not lessened in size from the commencement. It was suckled through the whole course, and seldom required the castor oil.—*Lancet, Oct.* 12, 1839.

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50. *On the Process of Reparation after simple Fracture of Bones.* By Bransby B. Cooper.—Twenty-four hours after fracture of the bones, a large quantity of extravasated blood is found effused into the cellular membrane of the muscles, filling up the spaces between the fractured extremities of the bones, and occupying the openings into the cancellated structure of each fractured extremity. The periosteum in the neighbourhood of the seat of fracture is also infiltrated with blood and thickened; so that a general extravasation of blood, attended

with tumefaction, is all that is to be observed as the immediate result of the injury.

The serous and red colouring matters of the blood now become absorbed, and shortly afterwards inflammatory action commences, which gives rise to the deposition of coagulable lymph. This adheres firmly not only to the periosteum, but also to the coagulum, which has now acquired a considerable increase in firmness, so as to produce a degree of stiffness of the limb which maintains the bone in a state of comparative rest. The effusion of lymph proceeds so as to fill the adjacent cellular membrane, to occupy the space between the separated fractured extremities of the bone, to thicken the periosteum, to fill up the interstices between the muscular fibres, and, in fact, to present so homogeneous a mass as to render it difficult to distinguish the various structures from each other. About this period the fractured extremities of the bones are found softened, granular, with their asperities partly removed, and firmly adhering to the surrounding lymph.

Blood-vessels now begin to be traced through the surrounding lymph, and an apparent anastomosis is established between the nutrient blood-vessels of the bone, those of the periosteum, and of the cellular membrane surrounding the lymph. A greater degree of firmness is also observed in the direction of the blood-vessels. This altered character of the effusion is most remarkable in the space between the fractured bones, where the lymph puts on the appearance of ligamentous bands more than that of cartilage. The whole mass, however, soon hardens and forms what is termed *callus*.

Contraction of the callus, apparently the result of interstitial absorption now commences, and continues till it produces a perfect contact of the overlapping extremities of the bone. A distinct cellular membrane may be observed between the muscles, forming a complete membranous covering to the callus, and continuous with the periosteum of the shaft of each portion of bone to some extent beyond the seat of the fracture.

Between the bones the callus now puts on the appearance of true cartilage, and at the point of contact no appearance of periosteum can be discovered. This interosseous cartilage is next converted into bone. Several red spots or discs are observed scattered irregularly through it, and round each of these osseous matter is deposited, which gradually extends through the whole mass. The extremities of such portions of the shaft as overlap each other, are now found to have lost the compact, and to have assumed a cancellated structure; so that if a longitudinal section be made through the fractured portions, the newly formed bone is found to be continuous with the cancellatud structure of each portion of the fractured bone. The whole medium of union is at this period enclosed in one continuous investing membrane, but no medullary cavity is yet formed.

The bone now grows less vascular, and a modelling process is established, by which the size of the adventitious deposit becomes reduced. The asperities of the bone are rounded off, grooves are formed for the passage of tendons, blood-vessels and nerves; and, finally, the medullary cavity is restored, when the process of reparation may be regarded as completed.—*Ed. Med. and Surg. Jour.* from *Guy's Hospital Reports*, No. VI.

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51. Ricord *on the Use of the Hydriodate of Potass in Syphilis.*—In the more confirmed, or, as M. Ricord has denominated them in his recent work, the *tertiary* forms of constitutional syphilis, no remedy appears to be so uniformly and so potently useful as the hydriodate of potash.

It certainly requires a good deal of practical tact to discriminate those cases to which it is more especially adapted. But, as a general position, it may be confidently asserted that, whenever a patient's system is deeply tainted—as for example, when the bones have become affected, or when it has become broken down or cachectic—this preparation of iodine is by far the safest, and also the most effectual, remedy that we can have recourse to.

The various eruptions, and, we may add, almost every form of cutaneous and mucous disease which are among the more early phenomena of the constitutional

infection, will be found to require, or at least to be much benefited by, the employment of mercury. Even in the treatment of these less severe affections, it is very useful to administer the hydriodate at the same time; as thereby the quantity of mercury necessary for the cure will be greatly diminished. We are not, indeed, of the number of those who attempt to refer all the worst cases of secondary syphilis to the maladministration of mercury; as we have repeatedly seen them occur in patients who had not taken a grain of it. But it cannot, nevertheless, be disputed that the indiscriminate use of this mineral in all the diseases, which are in any way connected with venereal infection, has been productive of the most pernicious results.

In almost every case of syphilitic affections of the periosteum and bone, M. Ricord has of late years renounced the use of mercury, and trusted to the hydriodate; associating it, according to circumstances, with sudorifics, tonics, bitters, &c. Most surgeons will admit that, when a bone has once become carious, the internal administration of mercury is hurtful. Now it is especially in such circumstances that the hydriodate may be given, not only with perfect safety, but with good hopes of decided advantage. Steel and other tonics may be usefully given at the same time; and the local treatment also must be strictly and judiciously attended to.

We could adduce an immense number of cases, not only of ulcerated tubercles, but also of venereal caries of the bones, to illustrate the truth of these remarks: but this would merely occupy a space which we cannot afford at present. The following extracts from M. Rattier's report of M. Ricord's practice embody the most useful hints.

"In our researches on the administration of the ioduret of potassium, we have been able to follow out the treatment of all the various forms of *tertiary* syphilis.

"Often the ioduret alone has been found sufficient for the cure; but, whenever any complication has happened to be present, it has received an appropriate medication.

"By having recourse at one time to tonics and stimulants, at another time to antiphlogistics, M. Ricord combines the various resources of therapeutics, according to the circumstances of each case; and in some patients who, in consequence of successive infections, have exhibited the disease in all its stages—primary, secondary, and tertiary—a local treatment has been directed to the chancres, the use of mercury* has caused the secondary symptoms to disappear, and the hydriodate of potash has been equally successful against the tertiary symptoms.

"Such is the basis of M. Ricord's treatment. If those principles, now explained, be not attended to, the physician will be apt to commit many serious errors; of which we meet with numerous examples in the assertions of those writers who have attempted to disparage the utility of the ioduret of potassium, on the ground that they have observed certain secondary symptoms resist its administration. Had a few mercurial pills been exhibited at the same time, these symptoms would speedily have vanished."

"In conclusion, the proto-ioduret of potassium amply deserves, in the treatment of *tertiary* syphilitic symptoms, all the praise which mercury is entitled to in the treatment of the *secondary* symptoms;—with this difference, that, very seldom or never, has it given rise to those numerous and distressing accidents which are too well known to have been frequently induced by the injudicious administration of its rival."—*Med. Chirurg. Review* and *La Lancette Française.*

52. *Wound of the Abdomen—Protrusion of the Bowels—Recovery.* A very remarkable case of this is mentioned by Mr. Alcock, in one of his lectures. A lady had stabbed herself in the abdomen, in a fit of jealousy. The surgeon first sent for, had endeavoured in vain, by dilatation and other means, to reduce the gut which protruded through the wound. "On entering the room," says Mr.

* M. Ricord has of late years trusted chiefly to the proto-ioduret of mercury.

A., "I found the patient lying on her back, with a large wet cloth over her person. On removing this I was somewhat startled by seeing the whole of the abdomen covered by the protruded intestines, of a dark red colour, against which the coarse cloth had been some half hour in contact; the patient almost continually vomiting, and at each effort fresh portions of viscera protruding. Our friend, in enlarging the opening, had increased, in a tenfold degree, the mischief; and finding that the woman's convulsive efforts protruded fresh portions upon him, had left her at last, frightened at the quantity exposed to view and his ill success in diminishing it. It appeared that an hour and a half had elapsed since the injury was inflicted. Several feet of intestine were exposed, many parts of a dark and purplish hue. A Portugese surgeon had been called in during the absense of the first, who declared she was a dead woman, and sent for the priest to administer to her soul. The intestines, with some difficulty and careful manipulation, were returned in a few minutes, and chiefly by taking care that, while the forefinger of one hand restored a small portion, the point of the finger was not removed, until by the right hand another portion was pressed down upon it in a similar manner. When all was returned, I passed a strong suture through the muscular parietes, closed the wound, and subsequently a rigorous antiphlogistic treatment was adopted. The woman not only perfectly recovered, but that which is more extraordinary, in five months she was safely delivered, having been four months advanced in pregnancy at the time she wounded herself.

"This is one instance among many which may serve to prove to you that a case, however desperate it may seem to you, should never be given up, and I need scarcely remark that nothing could be more reprehensible than the retreating tactics of the first operator. An operation once begun should always be concluded *secundum artem*—according to the circumstances of the case, however untoward may be the supervening results, or the accidents that may seem to render the operation unavailing. The surgeon will best consult the welfare of his patient, to say nothing of his own reputation, by seeing that the patient, even if death seem inevitable, die, at all events as regards the operation, surgically, if I may so express it. Sometimes he will find, in spite of all prognosis, the patient recovers. I have had a patient lie apparently dead under my own scalpel, and under that appalling circumstance I concluded the operation, and my doing so was the means of saving his life, when all around me had conceived it impossible, and he perfectly recovered.

"I cannot agree with some modern authors in their censure of sutures, and their recommendation, in the generality of cases, to dispense with them; even if the wound of the integuments and peritoneum be only an inch in extent, yet in nine cases out of ten a less suture will be required. It must be remembered that the patient is generally extremely restless; in the first instance most frequently convulsed with vomiting, the abdominal muscles in violent action or writhing with pain; and under these circumstances, how are folds of intestine just returned to be prevented from protruding, if not by a suture? No bandage or pressure can be endured, not even for a few minutes; how, then, is hernia to be prevented? By strips of sticking plaster? assuredly not. After again and again performing the same operation to the manifest injury of the patient—of handling and returning the gut, the surgeon will at last be obliged to resort to the only secure means, which he ought to have adopted at first, and passing a strong ligature through the integuments and part of the muscular parietes, close the wound and effectually confine the elastic contents of the abdomen."—*London Med. Gaz.*, Sept. 1839.

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53. *Penetrating Wounds of the Heart.*—M. Jobert (De Lamballe), in an interesting memoir in the *Archives Générales* for September last, gives an account of his researches relative to these injuries, principally directed to the discovery of a means of diagnosticating them.

The following are his conclusions:—

"1. That penetrating wounds of the heart give rise to a perceptible sound, similar to that heard in varicose aneurism.

"2. That they are accompanied with a *constant convulsive action* of the muscular fibres of the heart.

"3. That the sound just indicated ceases as soon as the wound is closed by a coagulum.

"4. That the convulsive action of the muscular fibres of the heart continue after the formation of the coagulum.

"5. That patients often die from a compression of the heart, and the formation of coagula in the interior of that organ.

"6. That the proper treatment consists, in the first place, of diminishing the mass of blood, even to syncope, with a view of lessening the action of the heart and favouring the formation of a coagulum."

There seems to us, we may remark, some discrepancy between his last two conclusions.

MIDWIFERY.

54. *Delivery of a Fœtus with the Secundines, the Membranes Unbroken.*—Dr. Victor Szokalski, in a communication in *La Lançette Française*, (March 28, 1839,) states that two days previously he had been called to a woman who had been suddenly delivered in the street. On the Doctor's arrival he found the mother seated in a chair. She was a robust woman, about 35 years of age. A glance sufficed to assure him there was no need of anxiety on her account and he directed his attention to *something* which a neighbour held enveloped in her apron; this was an infant, enclosed in its membranes, yet unbroken, motionless and exhibiting no signs of life. It had been born whilst the mother was walking, and had fallen on the pavement. Not being able to tear the membranes, they were so tough, with his fingers, he opened them promptly with a pair of scissors; when about six ounces of liquor amnii flowed out. The infant, a boy, seemed almost, at term, but feeble and emaciated. The umbilical cord was without pulsation; however, some beating of the heart was perceptible. Inspired with hope by this circumstance, Dr. S. cleared promptly the mouth of the infant, and applied frictions with flannel to the chest; he then washed every part of it with warm water, and in a few minutes had the pleasure to see the infant breathe. On the head of the infant, near the anterior margin of the frontal fontanelle, there was a small recent wound, which seemed to attest the fact of the child having fallen on its head, when ushered into the world.

The mother stated that this child was her tenth, and that she had always been delivered with extreme facility. This time she had advanced to the period of eight and a half months, and she attributed her premature delivery to a fall she had had a few days previously in the street. Labour pains had commenced the preceding morning, and as they increased towards evening, she went to the Hotel Dieu, but being refused admittance, she hastened towards the Clinical Hospital of the faculty, and on the way she dropt her burden.

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55. *New test for the detection of Pregnancy.*—Some years ago M. Nauche communicated to the Society of Practical Medicine of Paris, a memoir in which he endeavoured to show that the urine in pregnant women contains a peculiar substance, which separates by repose and forms a pellicle on its surface, and to which he gave the name of *kiesteine*, and that thus a valuable diagnostic sign may be derived by the obstetrical physician. But little importance has hitherto been attached to this alleged discovery of M. Nauche; and we are not aware of any accurate series of experiments which have been instituted with the view of determining the question, till M. Tanchou, of Paris, recently published his researches on the subject in the *Lançette Française*. (February 21, 1839.)